The Helsana Group comprises Helsana Insurance Company Ltd,
Helsana Supplementary Insurances Ltd and Helsana Accidents Ltd.

Helsana

Power of Attorney

For identification purposes, a copy of an official form of identification for the insured person must be enclosed. Please complete in full and legibly (in block capitals, if completed by hand).

Valid for

○ Basic insurance in accordance with the Federal Health Insurance Act (KVG)

○ Supplementary Insurance(s) in accordance with the Insurance Contract Act (VVG)

Insured person (Authorising party)

Name, Surname

Street, no.

Postcode, Town/City

Insurance no.

Telephone

Email

Authorised person

Name, Surname

Street, no.

Postcode, Town/City

Date of Birth

Telephone

Email

I instruct the Helsana Group to deliver the following documents to the authorized party on a one-off basis:

○ The currently valid insurance policy

○ Tax statement for year/s:

○ Other:

I authorise the abovementioned person to receive the following information respectively take the following legal action in insurance-related matters involving the Helsana Group:

○ Information of any kind, including particularly sensitive data

○ Changing of personal details (e.g. surname, marital status, address, bank account)

○ Change in coverage (e.g. annual deductible, inclusion/exclusion of accident, change in GP/ basic insurance model)

○ Cancellation of insurance coverage

Change of administrative address required?

○ Yes, I hereby request that all correspondence (in particular premiums, insurance policies etc. as well as sensitive data such as benefit statements etc.) are delivered to the authorised person.
This is applicable within the scope of KVG and VVG.

Information for the authorised person

Are you insured with us, and do you use the myHelsana client portal? If the answer is yes, you will receive all correspondence for the insured person digitally in your client portal or by post as well, depending on the communication channel selected in the portal.

○ No, I would like to receive all correspondence for the insured person by post only.

This power-of-attorney is valid as of the date of signature until such time as it is revoked in writing. I herewith unconditionally release the Helsana Group and all responsible employees from their duty of professional confidentiality, and their statutory duty of confidentiality vis-à-vis the authorized person appointed in this power of attorney.

Place and date	Signature of the insured person or their legal representative

Place and date	Signature of the authorised person

Please send the completed and signed form and a copy of an official form of identification for the authorising party to form@helsana.ch, as a myHelsana portal message or by post to Helsana Insurance Company Ltd, PO Box, 8081 Zurich.